DHS-CI-2021

# Application
Cochlear Implant Program

## Applicant Information

Applicant Name_____
*First* *MI* *Last*

SS#:_____ Birth date: _____ Gender: Male____ Female____

Does the applicant currently have one implant? Yes ☐ Age first implant received _____
No ☐

Parent/Guardian Name(s): _____

Address _____

City, State, Zip_____

County_____ Email Address _____

Primary Phone _____ Secondary Phone_____

## Medical Candidacy

Has the applicant been medically recommended for cochlear implant(s) by a Cochlear Implant surgeon?
Yes ☐ No ☐ *If no, you may submit your application, but this step will need to be completed before an eligibility determination can be made*

Is the applicant recommended for one or two implants? _____

Date of Surgery (if known)_____

Center Name _____

Center
Address_____
*Mailing Address* *City* *State* *Zip Code*

Center Contact Person_____

Phone _____Email Address _____

## Health Insurance

**Is the applicant covered under any Health Insurance Plan?** Yes ☐ No ☐

Policy Holder: _____Identification No. _____Group No. _____

Name of Insurance: _____Phone:_____

Address: _____

**Has coverage been approved or denied for the requested services?** Approved ☐ Denied ☐
*If coverage has been approved, please include documentation pertaining to out-of-pocket expenses such as deductibles, co-payments, and coverage limits*
*If coverage has been denied, please include documentation pertaining to denial including reason for denial*

**If health insurance has denied coverage, has an appeal been filed?** Yes ☐ No ☐
*If an appeal has been filed, please attach correspondence regarding the results*

**Does the applicant have Medicaid coverage?** Yes ☐ No ☐

**Has Medicaid approved or denied coverage for the requested services?** Approved ☐ Denied ☐
*Please attach relevant correspondence to or from Medicaid regarding approval or denial of coverage including documentation pertaining to appeals filed.*

Expenses not covered or not payable for some reason other than the deductible and coinsurance provisions in the health insurance plan are not eligible.

> *No amounts are payable by the telecommunication fund for the deaf for any portion of the cost of covered services listed in 46:30:08:03 covered by a health insurance plan or otherwise covered under another plan of insurance. The telecommunication fund for the deaf shall be secondary to any other insurance covering or providing reimbursement for the cochlear implant surgery, device, initial mapping and follow-up mapping.*

I declare and affirm that the information included in this application and additional information as required by the cochlear implant program is true and correct to the best of my knowledge and ability. I also acknowledge it is my responsibility to report any significant changes that could affect eligibility for the Cochlear Implant Program.

_____
Parent or Guardian Signature (or Applicant Signature if over 18)

_____
Date

**Submit application to:**
Hailey Bowers
Division of Rehabilitation Services
811 E 10th Street Dept. 21
Sioux Falls, SD 57103
P: 605-362-3630 F: 605-367-5327
Hailey.Bowers@state.sd.us